□ 1945

REMEMBERING DOUGLAS SELPH HENRY, JR.

(Mr. COHEN asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. COHEN. Mr. Speaker, earlier this week, Tennessee lost one of its most outstanding citizens, a person who loved Tennessee as deeply, if not more deeply, than anyone. Douglas Selph Henry, Jr., who served in the Tennessee State Senate in the Tennessee State House, served longer than any person ever did in the Tennessee General Assembly—44 years.

Senator Douglas Henry served 24 of those years with me. He was a gentleman, a scholar, a man who said he was a State man, as distinguished from a Federal man, and he was a public man, going to more events in Nashville in his district and for his community than anybody ever has. There was not an event that Douglas Henry wasn't there and helping to fund.

He was a conservative Senator. We had differences on issues many times. But Senator Henry was a man who you could disagree with, and he was never disagreeable. He was truly a gentleman at all times and a credit to his State and a credit to politics and a credit to his family.

He loved his wife, Lolly, who predeceased him, his five children, and his grandchildren. And though we differed on issues and he was pro-life, he cared about children after they were born, passed the mandatory child seatbelt law, and supported all types of education endeavors and endeavors to support mothers and young children. He was just a gentleman's gentleman. I was honored to spend time with him. It is a great loss to Tennessee. My thoughts go out to his family.

REPEAL OF THE AFFORDABLE CARE ACT

The SPEAKER pro tempore. Under the Speaker's announced policy of January 3, 2017, the gentleman from California (Mr. GARAMENDI) is recognized for 60 minutes as the designee of the minority leader.

Mr. GARAMENDI. Mr. Speaker, I rise this evening to cover several very, very important points.

Tomorrow is International Women's Day, and I was going to talk about the role of women in our society, talk about my five daughters and what they have been doing in their life of service, and my wife, but events intervened. And yesterday, our good friends on the Republican side introduced a piece of legislation that will dramatically affect women, young and old; children. They introduced a repeal of the Affordable Care Act.

We are still trying to figure out all of the details involved in it. It is going to be a little hard, since it was changed late in the night. But there are some things we do know. I would like to start off with what we do know about the Affordable Care Act so that when we come to debate on the floor in the days ahead the Republican repeal and replacement of the existing Affordable Care Act, we have a foundation.

If you will indulge me, I will try to lay out some facts, not alternative facts, but facts. For example, 20 million Americans have gained coverage as a result of the Affordable Care Act. The percentage of uninsured in America is the lowest it has ever been. Mr. Speaker, 6.1 million young adults between the age of 19 and 25 have gained insurance coverage by being able to stay on their parents' insurance program—6.1 million. Of the Americans who have preexisting conditions, and that is 27 percent of us who have some sort of preexisting condition—heart issues, diabetes, broken legs, bad backs, whatever—27 percent of those Americans are guaranteed coverage even though they have a preexisting condition.

I was insurance commissioner in California for 8 years, and I must tell you the battles—well, it would take several days to talk about the battles that I had with the insurance companies who were denying coverage because of preexisting conditions. No longer the case in America. The Affordable Care Act said no. And by the way, the lifetime limits, they are gone, also.

California, which I have had the pleasure of being a citizen of, 3.7 million Californians are now insured under the Medi-Cal program, and 1.4 million have gained coverage through the exchange, called Covered California. About 1.2 million of those have received subsidies, averaging over $300 a month. Over 5 million Californians will be directly affected by a direct repeal.

And in the expansion of Medicaid, or Medi-Cal as we call it in California, if that is eliminated, that is a $16 billion hit to the State of California, and, obviously, an enormous hit to those 3.7 million Californians who have been covered under the Medi-Cal expansion.

Secondary impacts: employment. Maybe 200,000 jobs would be lost in California.

Individual stories: boy, they abound. Just this evening, I got a call from my wife, and she said: You really ought to talk about that young family in Woodland, California, whose 2-year-old son was diagnosed with some sort of a medical illness. They were able to get coverage before that under the covered California program. They went back a year later, and the kid had a brain tumor.

Fortunately, it was resolved because they had insurance. They were able to get the early diagnosis. And under the current law, the Affordable Care Act, they will be able to keep their coverage, even though previous to the Affordable Care Act, this young child and, quite probably, the family would be uninsurable.

It is working. The Affordable Care Act is working. Are there ways to improve it? Undoubtably, there are, and we could sit down and talk about ways to improve it.

But yesterday, our Republican colleagues introduced legislation that is going to have a profound negative impact on men and women all across this Nation. We will spend time in the days ahead to talk about the details, but we do know that, in general terms, there will be less coverage at a higher cost for literally everybody, except for a few special folks. And I would like to just put up a chart about that. Let's start with this one.

You see, in the repeal bill that was introduced, there are very serious tax cuts. We are talking about hundreds of billions of dollars of tax cuts over the next 2 years. Well, we all want a tax cut. But under the repeal, there are some very special people who are going to get a really big tax cut. Take a look at this.

The top 20 percent of taxpayers will receive 74.2 percent of the multihundred-billion-dollar tax cut, which is estimated to be somewhere in the range of $700 billion to maybe as much as $1 trillion, depending upon the final calculations.

By the way, the Congressional Budget Office has not had time to score, that is to tell us what the cost, what the benefits are, of the Republican proposal. But we do know from earlier studies of this, 75 percent of the multihundred-billion-dollar tax cuts go to the wealthy. Wow. And where does the money come from? It comes from the poor, it comes from the working families, the men and women who are struggling here in America. Maybe they are making a good living—$50,000 to $60,000 a year. They are going to see their benefit package reduced.

One more way to look at this is the famous pie chart. So who gets the tax breaks? Not the top 20 percent. Let's just focus more clearly here on the top one-tenth of 1 percent. What do they get? They are not a percentage. This is not the top 1 percent. This is the top one-tenth of a percent. What do they get? Well, they get nearly $200,000 a year in tax reductions. That is not bad. So the top 1 percent gets 57 percent of that 6-, 7-, $800-billion tax cut, and everyone else will get 43 percent.

So what we have here is a massive shift of wealth from the working men and women of America, from American families, to the very top—you know, the 1 percenters. That is who is getting the benefit in this massive tax cut that has been proposed. I don't know if that is good policy. It is not in my district. I don't think it is good policy for America.

We spent a lot of this last year in the Presidential campaign talking about the shift of wealth to the superwealthy and away from the great majority of Americans. But, here we go. In the very first big legislation of this year, we see the Republicans in a massive effort to increase the wealth of the superwealthy at the expense of the rest of Americans.

There are many, many more things to talk about here. But I want to just take a deep breath, which I need, because I guess I am getting rather excited about what is happening—or maybe angry is a better word—and turn to my colleague from the great State of Virginia to carry on while I take a deep breath and cool off a bit.

Mr. Speaker, I yield to the gentleman from Virginia (Mr. SCOTT).

Mr. SCOTT of Virginia. Mr. Speaker, I don't blame the gentleman. I appreciate the opportunity to discuss the Affordable Care Act. As we discuss this, as he has indicated, it helps a little bit to talk about what the situation was before the Affordable Care Act passed.

We knew that costs were going through the roof. We knew that those with preexisting conditions, if they could get insurance, would have to pay a lot more for that insurance. We knew that women were paying more for insurance than men. We knew that millions of people every year were losing insurance. That is what was going on before.

People talk about small businesses. Well, small businesses had trouble getting insurance because if they had a person with a chronic illness, it would be unlikely that they could afford small-business insurance. But now, the costs have continued to go up, but they have gone up at half the rate they were going up before.

Those with preexisting conditions can now get insurance at the average rate. Women are no longer paying more than men. And 20 million more people have insurance, not millions of people losing insurance every year, 20 million more people have insurance.

Now, the full name of the Affordable Care Act is the Patient Protection and Affordable Care Act. There are certain protections, like insurance companies can't cut you off after they have paid a certain amount. There are no more caps. They can't rescind your policy. After you get sick, they can't just decide not to renew your policy. There is no copay or deductible for prevention and cancer screening. We are closing the doughnut hole. The average senior has saved already about $1,000 because of the Affordable Care Act support for closing the doughnut hole. Those under age 26 can stay on their parents' policies. Those are some of the benefits of the Affordable Care Act.

Now, we didn't solve all of the problems. There are still problems. But if we are going to change the Affordable Care Act, we ought to improve the Affordable Care Act. Unfortunately, the bill that was introduced in the middle of the night fails on a number of areas.

Now, we would know precisely how bad a bill it is if they would wait a couple of days for the CBO to score the bill. It would point out all of the flaws. But there are just a couple.

One is just a fundamental principle that it purports to cover preexisting conditions without a mandate for coverage. We know that if you allow people to wait until they get sick before they buy insurance, people will wait until they get sick before they buy insurance. The average insurance pool is sicker, more expensive. Healthy people drop out, and the thing spirals out of control. We don't have to speculate how this works because we know.

New York State tried it, and the cost went up so much that when the Affordable Care Act came in with a mandate, the cost for individual insurance dropped more than 50 percent. Washington State tried it. It got so bad that by the time it got going a couple of years, nobody could buy insurance. Nobody could buy insurance in the individual market. So we know what happens when you try to cover people with preexisting conditions without a mandate.

□ 2000

So this plan, when it starts off with that policy, we know it is bound to fail.

We also noticed another flaw: that it saves money by allowing people to purchase insurance that doesn't cover everything. We have people buying insurance now that have to buy the basic essential benefits package. When you can start picking and choosing, you might save a little money, but things like maternity care, if that becomes an optional coverage, then anybody that wants that will not be able to afford it.

It will cost whatever it costs to have a baby. They just have to pay the bill. They might as well not have insurance. So that is because, if anybody purchases maternity insurance, it is because they expect to have a baby in the coming year, and it becomes unaffordable. If everybody pays the average, everybody pays everything, then everybody can afford the maternity coverage.

So allowing people to pick and choose what they want, that might help a few, but those that need that coverage won't be able to afford it.

A final flaw, as the gentleman pointed out, is massive tax cuts. Well, when you reduce the revenue available, two things happen: there is less support for Medicaid, and there is less support for people in paying their premiums. So in the fullness of time, fewer people will be insured; and so you have a plan with fewer people insured, watered-down benefits, and a plan that is ultimately going to fail.

That is not an improvement. If we are going to deal with the Affordable Care Act, we ought to have an improvement; and until we have an actual improvement, we ought to leave the Affordable Care Act alone.

I am delighted to be here discussing the Affordable Care Act with the gentleman, warning people that, if they go forward without a Congressional Budget Office evaluation so they know what is going on, we may have a plan that is a lot worse than even before the Affordable Care Act.

Mr. GARAMENDI. Mr. SCOTT, thank you so very much. You bring to this discussion a very important perspective as the ranking member of the Education and the Workforce Committee. You have that perspective of understanding the effect of this legislation on the working men and women and families of the United States.

I was just looking at some of the early comments that have come out about the bill, which is less than—well, it is almost 24 hours old now. Families USA said: ''The GOP healthcare proposal would be laughable if its consequences weren't so devastating. This bill will strip coverage for millions of people and drive up consumer costs.''

The Catholic Health Association of the United States said: ''This proposal would also take many backward steps in the continual effort to improve our healthcare system. . . .''

It goes on and on, and as more and more people come to understand the issues that the gentleman was discussing, I think they are going to find that, no, we will take the Affordable Care Act as it presently exists, and we will make some modifications to it to improve it.

The gentleman raised a very interesting point. It reminds me of another conversation I had earlier this week with my wife. She had gone to her hairstylist, who is about 29 years old, has run her own business for the last 7, 8 years, and she told me wife: It can't be true. They can't do it, can they? They can't kill the Affordable Care Act, the ObamaCare?

She said: For the first time in my life, I was able to get insurance; and now that I have insurance, there is this maternity benefit that is in my package, and now my husband and I, we can afford to have a child.

It was directly to the point the gentleman was making. If there is an option here on maternity coverage or any coverage for women's health, then we are going to find a situation where people will pick and choose; they will wait to get their insurance, and then the insurance pool is left with very expensive cases and the cost is not spread out.

The gentleman may have some other examples that may have come along or some other comments that he would like to make. I would be delighted to have the gentleman share those on the floor, and I will yield to the gentleman.

Mr. SCOTT of Virginia. Shortly after the Affordable Care Act passed and went into effect, a young lady approached me in a store—she was a clerk in a store—and said: Bobby, don't let them repeal ObamaCare because my son is alive today because of ObamaCare.

I said: Well, what do you mean?

She said: Late last year, he was diagnosed with a fatal disease for which there is a cure, but we couldn't afford the cure. Thankfully, he lived to January 1, when ObamaCare kicked in, and we can afford the cure. My son is alive today because of the Affordable Care Act.

If it is repealed, what happens in that case? What happens in all of the other

cases when people don't have insurance? We have heard it represented that, well, anybody can get health care. All they have got to do is show up at the emergency room.

Well, yeah, that is fine. You can show up at the emergency room with a stroke, but you can't get blood pressure pills that could have avoided the stroke to begin with. They can stabilize you and send you home, but in terms of a cure or a surgery that may cure the problem, you don't get that. You just get stabilized in the emergency room, and that is not health care. We need people with insurance so they can obtain the preventive care and the corrective care that will get them off on the right track.

The gentleman talked about stripping coverage. When you take that kind of money out of the system, less support for Medicaid, fewer people getting Medicaid, less support for premium support so that people can actually afford it—if you look at the proposal, a lot of people can't use the tax cut because it is insufficient to pay the premium and they don't have the rest of the money.

So we need to make sure that CBO scores this. They will highlight all of these problems. They will show that many fewer people will be insured and that it is not an improvement. We shouldn't do anything unless we are actually improving the Affordable Care Act.

Mr. GARAMENDI. The gentleman is correct on that. I was just looking at some statistics here a moment ago about the shifting of cost.

Under the Affordable Care Act, there are many, many benefits for Medicare. Leaving aside the Medicaid population for a moment, the Medicare population, available to every individual 65 and older, there have been significant improvements.

You mentioned the doughnut hole earlier, the drug benefit. If you run up heavy expenditures on your drugs, you would come to a point where you had to pay 100 percent. Medicare didn't cover it. Well, that doughnut hole is collapsing, and in another 2 years, the Medicare program will cover all of the drug costs without limitation.

Also, there is the free annual checkup that is available to everybody that is on Medicare. The result of these kinds of things, where drugs are available, blood pressure drugs, diabetes and the like, has led to—together with the additional taxes that the superwealthy are paying—has increased the solvency of Medicare by 11 years.

Now, the fiddling that is going on with the proposal that our Republicans have put through, it is not clear exactly what the result would be; but we do know that one of the major tax cuts is the elimination of this Medicare tax that the superwealthy have been paying, and that is over—together with one other tax is almost $340 billion. So the support for Medicare and the solvency of Medicare becomes a question mark as a result of the proposals.

We don't have all of the answers to this, but we do know that a 60-year-old presently getting an insurance policy from the Affordable Care Act, from ObamaCare, and making somewhere around $40,000 a year—perhaps working at Walmart—they are going to see a 57 percent reduction in the tax credit that is currently available versus what the Republican bill has.

So a 60-year-old making $40,000 a year under the ACA, ObamaCare, will receive somewhere around a $9,000 tax credit to support the purchase of insurance. Under the Republican bill, they are looking at $4,000—not $9,000, but $4,000—so 57 percent reduction in the support that they receive, probably leading to them not being able to afford insurance and winding up in your emergency room example.

Mr. SCOTT of Virginia. To add insult to injury, part of the scheme is to allow insurance companies to charge senior citizens even more. Right now they are limited to three times what they charge everybody else. Their bill allows up to five times. That is a two-thirds increase in the cost. So if the tax credit wasn't enough to begin with, it is going to get worse.

Mr. GARAMENDI. Well, let me make sure I understand. I was 60 a while ago, but let's say I am 60 and I am getting a health insurance policy under ObamaCare, the Affordable Care Act. I may have to pay three times what a 25-year-old pays, but under the proposal that has been brought to us by the Republicans, I would pay five times?

Mr. SCOTT of Virginia. That is right.

When everybody pays an average, if you allow some people to pay more, some people are going to pay less, but it is a zero-sum game. Every time they show somebody can pay less, then know that somebody will pay more. They have a scheme, for example—they call it association plans—where you get a group of healthy people, they come from out of the insurance pool and get a better rate because the insurance company will look at the association and say: Those are the young, healthy people, I can give them a better rate. They can save money.

What happens to everybody else? They have to pay more.

Last time they came up with this idea, the research showed that 80 percent of the people will pay higher premiums if you allowed people to withdraw from the pool, a healthy group. Now, actually, it will always work, because the group you pull out, if the bids come in higher than average, nobody is going to buy the insurance. They are going to go right back into the regular pool. So any time you have one of these things, it will only work if you are pulling out young, healthy people, and that leaves behind, for everybody else, higher rates.

Mr. GARAMENDI. The fundamental nature of insurance is you gather a large population of healthy, not-so-healthy, and perhaps some very sick people into a large population, and the cost is spread across the entire population.

What we may be ceding here in this particular proposal is the unravelling of that fundamental insurance concept with young people, healthy, not bothering to buy insurance, staying out of the market; and then, eventually, when they become ill, they will get back into the market, leaving everybody else to pay for it.

There is another piece of this shifting of cost that did occur prior to the Affordable Care Act—significantly reduced, as a result of it—and that is the uninsured still get sick.

The gentleman mentioned the emergency room a while ago, and for the most part, in America, a person can get to an emergency room with or without insurance; but if they don't have insurance, there is still a cost associated with the visit to the emergency room and any other thing they may need. They may need to have their leg repaired, a broken leg, or maybe they need an appendectomy or whatever. That is still a cost. The question is: Who picks up that cost? That is called uncompensated care, and it was a huge problem prior to the Affordable Care Act.

I had hospitals throughout my district and throughout California coming to me and saying: We can't afford this because we are not able to cover that uncompensated care for people that didn't have insurance that showed up at the emergency room.

Now, we know that from the early analysis done of the proposed legislation by our Republican friends that the number of uninsured is likely to increase, perhaps as much as 11 million people—maybe more, maybe somewhat less. Those people will still get sick. They may have money of their own to cover their costs, but the chances are they don't. That uncompensated cost will then be borne by the people who do buy insurance. It is a cost shift to those who have insurance.

Mr. SCOTT of Virginia. In fact, when we passed the Affordable Care Act, the estimated cost on a family policy was about $1,000 a year on the family policy for uncompensated costs shifted on to the insured public. In fact, in Virginia, it is estimated that approximately $15 a month is paid on everybody with insurance, $15 a month to go to the 400,000 people that would have had insurance if we had expanded Medicaid.

So if you have 100 employees, you can just figure you are paying about $1,500 a month extra because we did not expand Medicaid. 400,000 people will go to the hospital, won't pay, and when people with insurance go, they just have to pay a little extra, about $15 a month per person in the Commonwealth of Virginia because of that.

Mr. GARAMENDI. There are so many pieces to this healthcare system.

One thing that I want to put on the table here from my experience as insurance commissioner in California is that there are two fundamental parts

to the healthcare system in the United States, and really around the world. One of those two parts is how we collect the money and then pay for the services. We call that insurance. It is also Medicare, Medicaid, veterans' programs, and the like. These are the way in which we collect money and pay for the services.

□ 2015

The other part of the healthcare system is the delivery of services; these are the doctors, the clinics, the hospitals, and other providers, mental health providers, and the like. We often get confused by putting these two things together.

There has been a lot of talk about what we are doing with the Affordable Care Act. It is essentially a mechanism to pay for services. It is an insurance mechanism. Using the private insurance system, these various exchanges are set up to pool the population of people who do not have insurance from their employer, the individual people, individual coverage. It pools them so that you have that large population so that the cost is spread out across that large pool and the insurance becomes affordable. That is an insurance mechanism. That is a pooling. It has nothing to do directly with the provision of medical services.

The medical services are then provided out of that pooling arrangement by the individual doctors, maybe clinics, maybe hospitals, maybe group practices. Some of that will be capitated pay, and others will be a fee-for-service.

We haven't changed directly the way in which services are provided, that is, the delivery of services. And this is found in hospitals. In the Affordable Care Act, there was a penalty for hospitals that had readmissions for infections. What we have seen, as a result of that provision dealing directly with the way in which services are delivered in hospitals, is a dramatic decline in readmissions for hospital-acquired infections. What that means is some 60,000 people are still alive today because they didn't get a hospital-acquired infection.

Mr. Speaker, I yield to the gentleman from Virginia (Mr. SCOTT).

Mr. SCOTT of Virginia. Mr. Speaker, well, that part of the Affordable Care Act has actually improved the quality of service.

There are other things in the Affordable Care Act, such as funding for education of more providers, more doctors and nurses, and other providers because we have a lack of professionals. One area, for example, is psychiatry. If the Veterans Administration hired all the psychiatrists they need, there wouldn't be any for anybody else. We are so far behind. And the Affordable Care Act provides for that service.

As you pointed out, there is a difference between the ability to pay for the services and the services that are there. People frequently compare the single-payer plan in Canada, which in many areas is a rural area. So you don't have the critical mass of population to support a high-tech medical system. So if you are going to have a baby, it is probably going to be delivered by a family doctor, not an obstetrician. In some areas, you have to go 200 miles to find a neurosurgeon. That doesn't have anything to do with the fact that they can pay for the services. It is just that the services aren't there.

So when people talk about the health delivery system, as you pointed out, that is different. The fact that you can actually pay for services doesn't diminish the opportunity to have those services there; it actually increases the possibility that those services will be there.

Mr. GARAMENDI. Mr. Speaker, that is exactly right, and I see that in my district. I have a large rural district in California. And, even today, there are areas where it is difficult to find a physician to get medical services.

This is one of the things, as you so correctly pointed out, the Affordable Care Act had a part of that. One of the titles dealt with the education of medical personnel. And so what we have seen, at least in California—and I suspect across America—with the Affordable Care Act in place, we are seeing that one of the fastest growing areas for new jobs is the healthcare sector because we are adding a lot of people—we need more—and then the educational programs that you talked about, which comes under the jurisdiction, I believe, of your committee. That is an important part.

One of the things that I hope the American public comes to understand is this is not just a sound bite that was used in a political campaign. We are going to repeal the ObamaCare and we are going to replace it is a nice sound bite. But we are talking about the lives of Americans, we are talking about their health, their ability to stay healthy, their ability to get medical services.

When you start tinkering with something that is so personal—that is what people say in my district: This is about my ability to stay healthy, my ability to get medical care. That is what I hear.

They are saying they are frightened. They are concerned that the legislation and all of the discussion in the political campaigns has been so heated that they are afraid they are going to lose what they presently have.

A quick look at what has been presented to Congress just in the last 24 hours indicates that a couple of facts are clear. First of all, there is an enormous tax break for the very, very wealthy, probably to the tune of 3- to $400 billion over 10 years. That is an incredible tax break for the superwealthy and for the health insurance industry. That, we are pretty sure, is in this legislation. We don't know the exact numbers; but we do know that early indications are that there is a shift, tax breaks for the wealthy, and cost increases for everybody else. That we know.

We also know that there are certain elements of support for individuals that will be removed. As we go about debating this and understanding the full import and get the Congressional Budget Office information, I think we are going to find that Americans are going to say: Well, wait. Wait, wait, wait. You are doing what to me? What are you doing to me? You are taking away my health insurance?

I suspect that will lead to a rebellion of some sort. Certainly it has agitated a lot of people in my communities about the justifiable fear of what may be coming to Americans.

Mr. Speaker, I yield to the gentleman from Virginia (Mr. SCOTT).

Mr. SCOTT of Virginia. Mr. Speaker, the gentleman indicated, in rural areas, one of the things that we have done is funded community health centers, which provides, where there are no professionals, a community health center where you can actually go to get comprehensive primary health care and then referred to a specialist somewhere if that is needed. That funding would be obviously in jeopardy.

As you pointed out, when you have tax cuts in terms of resources, that will translate into fewer people actually insured. They will have watered down benefits. And because there is no mandate to ensure that everybody is in the pool and they are trying to cover preexisting conditions, you have a prescription for disaster. That is not an improvement of the Affordable Care Act.

We need to insist that CBO score the legislation before we start taking votes so that people know exactly what they are getting into.

Mr. GARAMENDI. Mr. Speaker, the gentleman from Virginia is absolutely correct about that. Unfortunately, my understanding is that as early as tomorrow—that would be Wednesday—that the committees intend to mark up the legislation. Normally, that means the version of the legislation that will pass out of committee is completed. And, I suspect, usually it is associated with a vote that takes place in committee. We don't know for sure if it is tomorrow or the next day, but we do know that if it is this week, we will not have the Congressional Budget Office information.

The gentleman mentioned something that I probably should have jumped on immediately because of my rural district, and those are the clinics. As a result of the Affordable Care Act, there are now seven significant clinic organizations that provide services to about 23 specific sites around my district. They are providing, really for the first time in many of the communities that I represent, immediately available healthcare services to a variety of people, some of whom have had an employer-sponsored health plan and others of whom are on Medi-Cal in California.

The apparent reduction in the Medicaid, Medi-Cal for California, support from the Federal Government that will occur over the next 2½ to 3 years will eliminate one of the principal ways in which those clinics have been able to continue to operate and, that is, the expansion of the Medicaid population in California.

It appears that the legislation that is proposed will shrink the Medicaid program across the Nation and severely curtail in California the support available for people who are currently on Medi-Cal. That will be devastating to these clinics in these rural areas.

We have had discussions about this. They say: Watch carefully. If this is what happens, we are going to be out of business. We are going to shut down our doors.

Mr. Speaker, I yield to the gentleman from Virginia.

Mr. SCOTT of Virginia. Mr. Speaker, the clinics will shut down. Insurance companies will stop writing insurance if people can wait until they get sick before they buy insurance. The insurance companies reacted to that system in Washington State by selling nobody any insurance. So we know what is going to happen.

The CBO, when they score this, will point that out, and we will know exactly what the problems are.

Mr. GARAMENDI. Mr. Speaker, I thank the gentleman from Virginia (Mr. SCOTT) for joining us this evening. This is a fundamental part of American life, that is, our health care. It is about 18 percent of the total GDP, gross domestic product. It is extremely important in terms of the total well-being of our society and our economy.

Changes to the Affordable Care Act that are being proposed will have a dramatic effect. And what we do know about it is that there will be a massive shift of wealth from working men, women, and families to the superwealthy. We know that from the tax proposals that have been made in the analysis of the tax.

We also know that there is a very, very high probability that perhaps 11 million people will lose their insurance coverage, either in the private insurance market through the exchanges or through the Medicaid programs across the Nation. And the effect on the providers, the hospitals, the clinics will be profound.

So when we have something as important as this, it is just wrong. It is wrong for the majority in this House to put this legislation before the committees without a full hearing on what the effect will be. But it appears that tomorrow, Wednesday, we will have the first markup in this process.

What I want—and I think the gentleman from Virginia (Mr. SCOTT) does, too—is for the American public to hear the debate, to understand the implications where we are today with the Affordable Care Act and what it has brought to us in terms of quality and accessibility to health care and what it would mean with the proposed changes.

Mr. Speaker, I yield to the gentleman from Virginia (Mr. SCOTT).

Mr. SCOTT of Virginia. Mr. Speaker, I thank the gentleman from California for organizing the Special Order so that we could actually discuss some of the problems with going forward without a CBO score, without knowing what we are doing. Certainly, it is not an improvement in the Affordable Care Act.

Mr. GARAMENDI. Mr. Speaker, I thank the gentleman from Virginia (Mr. SCOTT) for expressing Virginia's view. From California, it is, whoa, wait a minute, let's be careful.

Mr. Speaker, I yield back the balance of my time.

TOPICS OF THE DAY

The SPEAKER pro tempore. Under the Speaker's announced policy of January 3, 2017, the gentleman from Iowa (Mr. KING) is recognized for 60 minutes as the designee of the majority leader.

Mr. KING of Iowa. Mr. Speaker, I appreciate the privilege to address you here on the floor of the House of Representatives, and I have a number of topics I would like to bring up this evening.

First, I would comment that I heard the words ''Affordable Care Act'' multiple times in the previous hour, and it just caught me each time I heard that. Abraham Lincoln would have had a difficult time saying such a thing being Honest Abe, and George Washington probably couldn't have said it at all.

As we know this, it is not affordable care and that is the reason that we have to address it. We knew this was going to happen. Of all the horrible stories we have heard about ObamaCare—this thing they call the Affordable Care Act—many of them were predicted here on the floor of the House of Representatives, Mr. Speaker. I predicted quite a lot of them myself, as did many of the Members who fought against that piece of legislation that was jammed down on us by hook, by crook, by legislative shenanigans.

We could see what was going to happen with this. It was slammed together by trying to circumvent the majorities, by pushing some things through on reconciliation. And we ended up with a piece of legislation that was the biggest bite they could get to create socialized medicine.

The worst part of ObamaCare, Mr. Speaker, was this: That it is an unconstitutional taking of God-given, American liberty. We are—and at least used to be and believe we are to be again—the freest people on the planet; and that our rights come from God; and that government can't take them away.

Many times here on the floor, I have said, Mr. Speaker, that the Federal Government hasn't figured out how to nationalize or take over our soul. That is our business, and we manage that. Our souls are the most sovereign thing that we have and are.

The second most sovereign thing we have and are is our skin and everything inside it. It is our health. It is the management of our health. And if Americans are not capable of managing their own health and making their own health decisions and pressing the marketplace to produce the health insurance policies that they desire, if Americans can't make those decisions, then it would just stand to reason, if that is true—and that is what Democrats seem to think—then there aren't any people on the planet who can manage their own health.

What I am pretty sure of is that if we don't think that regular, red-blooded Americans—especially those who are out there punching the time clock, running their business, starting a business, or working on commission, whatever they might be doing, the salt-of-the-Earth Americans—if they can't manage it, I am really sure that a bunch of leftists who are elected to office out of the inner cities of America aren't going to be able to do it.

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And we have seen the success of that, the leftist agenda of ObamaCare, imposed upon America, commanding that we buy policies that are approved by the Federal Government. They would have liked to have established the Federal Government as being the single-payer plan and abolished all insurance whatsoever and simply taken care of everybody's healthcare needs so that one size fits all, and we could drift down into the mediocrity that most the rest of the world has exhibited for a long time.

This all started back in Germany in the latter part of the 19th century, when Otto von Bismarck decided that if he was going to get reelected, he had to make the Germans dependent upon him. And so he devised this plan called socialized medicine and he, more or less, trained the Germans to expect the federal government to make those decisions for them, pick up the costs for them; and, in doing so, that sense of dependency got Bismarck reelected in Germany.

Well, it is not that old a country in Germany, but this idea of Marxism comes right out of there. By the way, there is a bench in Berlin that honors Karl Marx, and a number of other statutes and monuments as well. That is where this came from, and we watched as other countries adopted it.

I once picked up—Mr. Speaker, I had a World War II veteran who came over to an event that I was doing in Hospers, Iowa, and he had gone up to his attic and he brought down these Collier's magazines. They were original Collier's magazines that started right at the end of the Second World War and went on through those years, for 2 or 3 or 4 years, and they were yellow and, of course, they were dated, and he presented them all to me.

He said: I want you to have these. I want you to read down through these